Student Resources (SPC) Ltd.
A UnitedHealth Group Company
PO BOX 809025
DALLAS TX 75380-9025
(800) 767-0700

Insured: MD AZIM ULLAH
Patient: MD AZIM ULLAH

Policy#: 17-3247-91
Claim #: 17184475-01-01

Date: 02/23/2018

MD AZIM ULLAH
3467 Southern Ave Apt 4
Memphis TN 38111

SRID: 6598357 SECOND REQUEST

We are pleased that you are participating in an insurance plan provided by StudentResources, a UnitedHealthcare Insurance Company.

We have received a claim(s) for you. Before processing this claim, we need to verify that you meet the plan's Eligibility requirements. The Eligibility requirements are outlined in the brochure provided to you when you purchased the plan. Brochures are also available online at www.uhcsr.com.

Please print and complete the following information below and have it signed by the Registrar. If you cannot get this letter completed by the Registrar, then you must mail the completed letter and attach either the verification of enrollment from the National Student Clearinghouse or a copy of your current transcript.

School Name: _____

For the 2017/2018 Spring/Summer academic year, please provide:

Student Classification (Please check):

Domestic: _____ International: _____

Study Classification (Please check):

Study Abroad: _____ Optional Practical Training (OPT): _____

Undergraduate: _____ Graduate: _____ PhD Candidate: _____

Visiting Faculty Scholar: _____

English as a Second Language (ESL): _____

Other (please specify): _____

Total Enrollment Hours (Please Check):

Fulltime: _____ Part-Time: _____ Less than Part-time: _____

Other (please specify): _____

Enrollment Dates:

FALL	SPRING	SUMMER
_____ TO _____	_____ TO _____	_____ TO _____

Credit Hours:	FALL	SPRING	SUMMER
Classroom:	_____	_____	_____
Internet/Online Classes:	_____	_____	_____
Home Study Classes:	_____	_____	_____
Labs/Clinical:	_____	_____	_____
Dissertation/Research:	_____	_____	_____
Not taking Classes:	_____	_____	_____

Please Note: If you are taking less credit hours than specified in the Eligibility Requirements of the plan, or you are graduating at the end of the term for which coverage is purchased, please attach a letter from the Registrar confirming this.

School Registrar Verifier: (Please print)

_____	_____	_____
Name	Date	Telephone #

_____	_____
Verifiers Signature	Title

You may provide the requested information using any of the following methods:

* Email to customerservice@uhcsr.com

* Mail to address listed above.

Please note, the transmission of information via email is not a secured method. If you elect to return your Protected Health Information to UnitedHealthcare StudentResources via email, you have voluntarily made the decision to utilize an unsecured transmission.

IMPORTANT:
We are dedicated to processing all claims as quickly as possible; however, we need additional information in order to continue. Unfortunately, if we do not receive this information in a timely manner, we may have to deny all current and subsequent claims as being incomplete. We appreciate your assistance in helping us process the claim(s) as quickly as possible. If you have any questions, please contact Customer Service at the number on your ID card or (800) 767-0700 between the hours of 7:00 AM and 7:00 PM Central Standard Time Monday through Friday.

Sincerely,
Claims Department
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LETTER NO: 41
LETTER DCN: 180549307755
SRID: 6598357
<END>